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PRACTICAL HINTS

ABOUT

SYMPATHETIC DISEASES OF THE EYE.

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—BY—

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# SYMPATHETIC DISEASES OF THE EYE.

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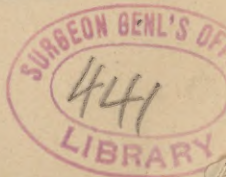
Dr. C. A. BUCKLIN. ✓

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UNDER the above title I wish to call attention to some facts of the greatest possible importance. Having been brought so frequently face to face with this horrible condition known as sympathetic diseases of the eye, I shudder when I think that the sad fate of the patient is too frequently the result of a failure of some family practitioner or too positive specialist to appreciate the intricate nature of the trouble or the hidden danger which is lurking under a calm exterior. They fail to fully explain and warn the patient of the danger which may follow in time, and complete blindness is the result. The time required from the injury until the other eye is destroyed varies from a few weeks to forty years.

It is impossible to consider in our limited space the entire details of sympathetic disease of the eye. The entanglement of one of the various nerves which run between the coatings of the eye in considerable numbers in a *scar*, or any other constant source of irritation existing in an eye, as *chronic inflammation*, *calcarious deposits*, foreign bodies, scars resulting from a wound, a cataract which is over ripe and has become calcarious may cause the destruction of the eye, the fellow eye, or both eyes. I desire to present only such illustrative cases as will cause the careful to think and the careless to beware. I present the facts as they exist, not with an intention to criticise, but with a pure desire to do the greatest good.

Case I.—Mrs. B., age 50. In May the right side of the face





was covered with an eruption which followed an attack of malaria. The eruption caused a severe burning and itching sensation of the right side of the face, which later became covered with a yellow crust. The line of division, however, between the crust-covered right side of the face and the left side was very sharp. At this stage she consulted a physician who considered the disease acute eczema ("salt rheum") and treated it as such for three months, when one of the pustules appeared upon the cornea. It ulcerated, the eye ball was perforated by the ulcer, the pupil became extensively attached to the wound, the eye was lost by inflammation which invaded the eye ball, and three months later the other eye was affected by sympathetic disease. The sharp line of division between the affected and healthy side of the face should have attracted the attention of the physician at once, and caused him to recognize the trouble as arising from an inflamed nerve.

This case illustrates the importance of recognizing and properly treating diseases of the fifth nerve. A failure to make a correct diagnosis in this case made a blind woman, when a correct diagnosis would have lead to a favorable termination of the disease.

Case II.—Mr. M., age 33, was chipping cast iron in 1865, when a piece of the iron or chisel struck him on the margin of the cornea. It made a simple clean wound on the cornea, through which the margin of the iris prolapsed. The eye at the time I saw it looked exactly as if Critchett's operation for displacing the pupil had been carefully performed by a skilled operator. He retained fair vision in the injured eye. He consulted his family physician and several specialists of this city; each and every one of them were enthusiastic in their explanation of their patient's good luck in having a sharp piece of iron strike the eye ball and do so little damage.

The general verdict was: "*It is a very fortunate accident.*"—"*The eye is all right.*"

Let us now observe the consequences and see how unfortunate the accident was, and how fortunate it would have been for the patient had the eye been so mutilated that its immediate removal would have been necessary. All attempts to use his eyes for any length of time fatigued him. His business called him upon the water

in 1873, eight years after the accident; he began to see dark clouds pass over the water, or he would observe an undulating appearance of the water which none of his companions could see. It was three months after he first saw these dark shadows before he saw them again.

The periods became more frequent. Within one year from the appearance of these dark shadows, the *uninjured* eye was totally blind, and only sufficient vision remained in the *injured* eye to enable him to read large print with difficulty. No one had considered the injury serious, and no one warned him of the possibility of the other eye being lost by sympathy.

The operation of Critchett's for displacing the pupil has, in many instances, brought about the same sad consequences years after the patient has passed beyond the observation of the surgeon.

Case III.—Mr. M., struck in 1859 upon the sclera by a sharp piece of steel which perforated the eye but did not enter the ball. It glanced off. The choroid prolapsed through the wound, and, at the time of examination, looked like a black pin head on the white sclera under the conjunctiva.

To show that there is a possibility of every one being mistaken about the consequences which may follow such a simple accident, I casually mention the fact that he repeatedly consulted our most respected authorities on ophthalmology about the black speck on his eye. They assured him that it was a matter not worthy of attention.

In 1873, fifteen years after the accident, his eye began to tire easily—he began to see smoke in the atmosphere, the vision would periodically become obscure—at last the acuteness of vision became permanently obscured. All efforts to use the eyes produced an immediate sensation of fatigue and were disagreeable to him. He was sent to me by an optician to see if glasses would remedy the trouble. Upon observing the choroidal hernia, I suspected a ciliary nerve was implicated. I cut down by way of experiment, and cut the hernia off as close as possible to the wound, from which I freed it as thoroughly as I could. The vision at that time was  $\frac{20}{70}$  of normal vision. The strange feature in this case which surprised me as much as it will any of my readers is, that in eight days the vision increased to  $\frac{20}{80}$  of normal vision, and all unpleasant symptoms disappeared.



Those who propose to open the eye to introduce magnets or transfix the choroid with needles, should remember that this case illustrates the possibility of doing a damage which may fifteen years later cause both eyes to be lost, although the *original object* for which the magnet or needles were introduced was well accomplished and successful. Such patients cannot be too thoroughly cautioned as to the possibility of danger years afterward, and the symptoms which announce its approach should be carefully described; such as mist before the uninjured eye—dark shadows which appear periodically, flashes of light—great fatigue upon attempting to use the eyes, etc.

Case IV. illustrates an example of a careful specialist who is thoroughly aware of the danger while treating a child on the expectant plan. The child has an ulcer of the cornea, which sloughs and a large portion of the iris becomes fast in the ulcer. This is followed by severe inflammation within the eye ball for which she is treated, while the other eye is being kept under observation. The mother is told to bring the child back in four weeks, as the inflammation in the injured eye has quieted down. In six weeks she returns with the child, and imagine the mental chill which must pass over one when he looks into the *uninjured* eye, and sees delicate cyclitic membranes stretching entirely across the field of vision. It is too late to enucleate the offending eye—*the child is blind*. There was no warning in the shape of a complaint from the child. There was no decided injection of the eye to attract the attention of the mother or physician.

Specialists are frequently deterred from doing their duty by the outside pressure of parents, friends, physicians, and dishonest or sometimes ignorant "*eye doctors*," who are willing to give a favorable prognosis on no other grounds than a desire to please the family.

I believe, in children upon whom we cannot rely for early information regarding symptoms in the other eye, it is the duty of the specialist to strongly advise the removal of every eye which decidedly endangers its fellow eye.

Case V. — Mr. R. At age of 20, cataract developed in one eye from unknown cause. *At fifty*, sympathetic irritation appeared in other eye in the form of flashes of light. Enucleation of offending

eye arrested further development of disease in uninjured eye. The lens was calcarious, and calcarious deposits were thickly distributed through the ciliary body. There were evidences of an old intra-ocular inflammation with extensive detachment of the retina. The disease not being traumatic was evidently specific.

Case VI.—Mr. L., struck in the eye with a cow's horn during boyhood. At the age of sixty, the other eye, which had behaved well during this time, is affected sympathetically, the development of which affection is announced by dark shadows followed by flashes of light, and entire loss of the uninjured eye follows.

The last two cases bring us to a practical point regarding cataract extractions.

How often has the following rule been laid down to students of ophthalmology: *Never remove a cataract before it is ripe.* Meaning as long as fingers can be counted.

*Never remove a cataract from an eye when it is plain that no visual improvement can be attained,* unless the patient desire it done for cosmetic purposes.

*Never remove a cataract as long as there is good vision in the other eye.*

In all cases of cataract except the congenital variety, the crystalline lens is undergoing progressive atrophy, the vitreous is becoming fluid, and the intra-ocular blood vessels are becoming weak. Calcarious deposits are quite sure to form in the hyper-mature cataract.

Is it not better to disregard all these rules and remove the diseased lens at such time as it can be removed with the greatest safety to the patient? A calcarious lens is a dangerous thing to have in an eye, and also a very dangerous lens to remove by the usual method of opening the capsule, the calcarious debris being liable to fall into the eye during the évacuation of the lens.

I have seen both eyes totally lost within ten weeks after such an accident. The operated eye was destroyed by severe intra-ocular inflammation, and the eye not operated upon was destroyed by sympathetic disease.

If it can be seen that a lens is filled with calcarious deposits and it is to be removed, it is better to remove it in its capsule entire.



This is a dangerous operation under the most favorable circumstances, and still more liable to cause loss of vitreous and also intra-ocular hemorrhage in cases where the lens has remained in the eye till it is filled with calcarious deposits.

Having waited till this stage, one is between two fires; and it is impossible to judge which is the more dangerous, the chance of dropping calcarious deposits into the eye by the ordinary method of extraction, or the chance of causing intra-ocular hemorrhage or severe inflammation by the violence done the eye in attempting to remove the lens in its capsule. I prefer to remove the lens as soon as they cannot count fingers at a greater distance than two feet. In the majority of cases this avoids all serious complications. The lens comes out easily. There are no calcarious deposits in it. The vitreous and intra-ocular blood vessels are in a healthier state than they ever will be at any subsequent time.

When I see some specialist of experience who is willing to have the lens and capsule *torn* from his own eye, I shall believe that this method of removing the cataract in its capsule has one enthusiastic and honest advocate. I will not do an operation on a patient's eye that I would not ask a colleague to perform on my eye if I were the patient.

Pagenstecher probably made more money than any operator will again by professing always to remove the lens in its capsule; thus completing the entire operation at a single stroke. He drew cataract cases from every city in Germany and Austria. He appeared to advocate the operation very strongly, and from his monograph, one would think that he believed it to be quite as safe as any method of removing cataract. Patients have frequently been seen who were positive in their assurance that Prof. P. had removed their cataract with its capsule. Examination showed, however, that the capsule had been opened by the usual method. These cases have caused me to believe that during his extensive experience with this operation, he had some unpleasant experiences which he forgot to publish in connection with his successes.

In iritis, we sometimes see a nodular appearance of the surface of the iris; this is due to circumscribed portions of the iris being so



sealed down to the lens that local cavities are formed in which fluid accumulates and lifts the iris, forming an elevated nodule of which there may be several. Such eyes, as visual organs, are of no value; they are almost sure to set up sympathetic disease in the other eye, the only preventive measure against which is enucleation of the eye. If the family do not indorse this operation, let some kind-hearted colleague take the case and also the responsibility. Iridectomy in these cases is of but little value. When the entire margin of the pupil is fast to the lens or cornea, iridectomy is usually all that will be required to make the offending eye safe.

Having illustrated what may happen to those who do not appreciate the dangers which may arise from sympathetic disease of the eye, we will mention two cases which will illustrate what the over zealous specialists do occasionally.

Mrs. C., aged 50, has acute syphilis. Right eye develops plastic iritis with multiple adhesions of the margin of the iris. Four months later, simple plastic iritis breaks out in the left eye. She visits two of our city eye institutions. The pupil of the last affected eye dilates readily under atropine, with one marginal attachment of the iris to the lens. The disease of the second eye is declared sympathetic. The enucleation of the right eye is most urgently insisted upon at both institutions. I freely confess that I am not so bold as to advise the removal of an eye that still has a good visual field, because plastic iritis has broken out in the fellow eye suddenly and without any premonitory symptoms.

The syphilitic eruption being in a most flourishing condition, is it not more judicious to call the iritis of the *second* eye syphilitic, and to treat it energetically as such, rather than enucleate one eye before you are sure that the *enucleation* of the eye will not have a disastrous effect upon the fellow eye which is already in a dangerous and irritable condition. It must also be remembered that such eyes, as a rule, do very well without enucleation.

Mr. R., age 25, had syphilitic iritis of one eye which caused extensive pupillary attachments of the iris to the lens. The pupil appeared blocked with a mass of exudation. Several weeks later, the second eye was attacked with plastic iritis. The advice given by

several specialists was to enucleate the bad eye at once. He was treated for syphilis and iritis; at the end of four months the eye with which he could read, was the one the enucleation of which had been strongly advised.

A single adhesion of the iris to the lens is more dangerous than two or more adhesions so situated that the movement of the iris is limited. Such eyes are only to be operated upon when sympathetic irritation appears in the fellow eye, or the attachment of the margin of the iris to the lens becomes complete and water-tight. This condition can only be diagnosed by the pupil becoming sunken or "crater-shaped," thus proving that fluids can no longer escape into the anterior chamber.

Adhesions of the iris to the cornea are more liable to be followed by sympathetic troubles, than adhesions of the iris to the lens.

These few cases, selected from a large number of similar ones met with in the course of my practice, serve to illustrate the folly of too much conservatism when an eye has been lacerated, or a ciliary nerve is being irritated by disease, injury or a foreign body. In such cases, attempts to save the injured eye, will invariably result in the loss of both.

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